

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3172

CERTIFICATE OF DEATH

03155

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 217 Hollingsworth Manor		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Dallas	Middle x M.	Last ADAMS	4. DATE OF DEATH MARCH 9 1958	Month MARCH	Day 9	Year 1958	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 30, 1911	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 MRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Marion Dalton				14. MOTHER'S MAIDEN NAME Delia Phillips				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT James W. Adams		Address Elkton, Md. 217 Hollingsworth Manor,		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION INTERVAL BETWEEN ONSET AND DEATH 11 DAYS								
54.1.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PERITONITIS 10 DAYS								
DUE TO (c) PERFORATED RUPTURED GASTRIC ULCER 10 Days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) CHESAPEAKE CITY MD		(State)
21. I certify that I attended the deceased from Feb 27, 1958 to MARCH 9, 1958 , that I last saw the deceased alive on MARCH 8, 1958 , and that death occurred at 2:20 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE Henry V. Davis M.D.								
PHYSICIAN'S NAME (Type)		HENRY V. DAVIS CHESAPEAKE CITY MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/58		22c. NAME OF CEMETERY OR CREMATORIAL PARK Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) (State) Elkton Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DeLoach		24b. REGISTRAR'S SIGNATURE DeLoach		
VS A15 (4) 15M 9/55				DATE MAR 13 '58				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03156

3173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 136 Maffitt Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Mary	Middle Alice	Last Boyd	4. DATE OF DEATH March	Month 26	Day 19	Year 58
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1885	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Peter Charles Boyd	14. MOTHER'S MAIDEN NAME Joanna T. Connors
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-32-1394	17. INFORMANT Mrs. Rose Stevens, Elkton, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 12 days
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 15, 1958, to March 26, 1958, that I last saw the deceased alive on March 26, 1958, and that death occurred at 3:50 PM, from the causes and on the date stated above.		
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ACTUAL SIGNATURE <i>S. Ralph Andrews, Jr.</i>	ADDRESS (Street, city or town, state) 233 E. Main Street	DATE SIGNED 3/27/58
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PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.	Elkton, Maryland
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/29/58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cemetery	22d. LOCATION (City, town, or county) Harrisburg, Pa.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Nicks</i>	ADDRESS Elkton, Md.	24a. REC'D BY REGISTRAR MAR 31 1958	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>
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CERTIFICATE OF DATA

BUREAU X-5

MAR 31 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3190

CERTIFICATE OF DEATH

03157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, RD		c. LENGTH OF STAY IN 1b 42 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville Rural		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES		First 0.	Middle .	Last BURTON	4. DATE OF DEATH March 24	Month March	Day 24	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/83	9. AGE (In years lost birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Burton				14. MOTHER'S MAIDEN NAME Katherine Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Effie P. Burton, Perryville, RD, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Myocard. Dis - Failure						INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Cerebral Vascul - Accident							
(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore, Md.	(County) Baltimore	(State) Md.	
21. I certify that I attended the deceased from Tuna , 19 55 , to March 27 , 19 55 , that I last saw the deceased alive on March 23 , 19 55 , and that death occurred at 9:00 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE 	M.D.		ADDRESS (Street, city or town, state) 1807 E. 30th St., Baltimore, Md.		DATE SIGNED Mar 27 '58				
PHYSICIAN'S NAME (Type) G. H. Richards, Jr., M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/27/58	22c. NAME OF CEMETERY OR CREMATORIUM Principio Cemetery		22d. LOCATION (City, town, or county) Principio Furnace, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE 	ADDRESS Perryville, Md.			24a. REC'D BY REGISTRAR MAR 27 '58	24b. REGISTRAR'S SIGNATURE 				
VS A15 (4) 1SM 9/55									

BUREAU Y.
RECEIVED

MAR 27 1968

RECORDED COPY OF DOCUMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3174

CERTIFICATE OF DEATH

Reg. Dist. No.

03158

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elikton		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b One day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Conowingo Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ernest	Middle George	Last Carter
4. DATE OF DEATH	Month March	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1902
9. AGE (In years lost birthday) yrs. 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Mushroom House	12. BIRTHPLACE (State or foreign country) Rowlandsville, Md.
13. FATHER'S NAME Edward Carter	14. MOTHER'S MAIDEN NAME Anne J. Boddy	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) 160.0	
16. SOCIAL SECURITY NO. 222-10-8457		17. INFORMANT Mrs. Helen Alexander	Address Rising Sun MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Nose extending to the sinus DUE TO causing Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-25 , 19 58 , to date 3-7-58 , 19 58 , that I last saw the deceased alive on 3-7-58 , 19 58 , and that death occurred at 8 P M, from the causes and on the date stated above. ACTUAL SIGNATURE R.C. Dodson PHYSICIAN'S NAME (Type) R.C. Dodson M.D.		ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 3-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 11, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zoar	22d. LOCATION (City, town, or county) (State) Near Conowingo, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Carl Tyson, Rising Sun	ADDRESS 1	24a. REC'D BY REGISTRAR MAR 11 '58	24b. REGISTRAR'S SIGNATURE Aut. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HIGHWAY-POLICE

CERTIFICATE OF DEATH

Information on the above application to file death

Death certificate

22

BUREAU U.S.
MAR 11 193
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3191 CERTIFICATE OF DEATH

03159

Reg. Dist. No. 9A

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 3mos12days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) FLETCHER		First F.	Middle .	Last CARTER	4. DATE OF DEATH March 15 1958	Month March	Day 15	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-16-90	9. AGE (In years lost birthday) yrs. 67	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 7	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Shelby, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Mack S. Carter		14. MOTHER'S MAIDEN NAME Nannie Deramus		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. None			17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X Hemorrhage, cerebral, right sided.		DUE TO Generalized Metastases - ("Brain, Lung, Liver, Kidney, Bones and Supra-Renals.)		DUE TO Hypernephroma, right kidney.					INTERVAL BETWEEN ONSET AND DEATH 7 Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {		(b)		(c)					Over 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									Over 1 year.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA Hospital, Perry Point, Md.	(County) 3-16-58	(State)		
21. I certify that I attended the deceased from 12-3 , 19 57 , to 3-15- , 19 58 , and that death occurred at 8:45PM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	DATE SIGNED 3-16-58
ACTUAL SIGNATURE E. S. Ells,		M.D. VA Hospital, Perry Point, Md.								
PHYSICIAN'S NAME (Type) E. S. Ells, M.D., Acting Director, Professional Services.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-19-1958	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Principio Cemetery		22d. LOCATION (City, town, or county) Principio Furnace, Maryland		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE See A. Patterson + Son		ADDRESS Lee A. PATTERSON & SON, Perryville, Md.		24a. REC'D BY REGISTRAR MAR 18 '58	24b. REGISTRAR'S SIGNATURE G. W. Beach					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DELIVERY

MAR 18 1968

RECEIVED

BUREAU V. S.

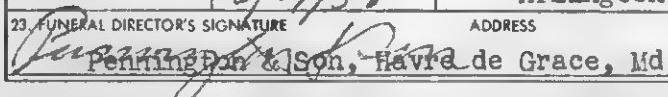
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03169
96

3192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 10yrs. 3mo. 11days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco		d. STREET ADDRESS ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE IN A HOME Washington		
3. NAME OF DECEASED (Type or print)	First FRANK	Middle H.	Last CHESLEY	4. DATE OF DEATH March 11 1958	Month March	Day 11	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-18	9. AGE (In years last birthday) 39 yrs	IF UNDER 1 YEAR Months 39	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Hilton Chesley - Deceased			14. MOTHER'S MAIDEN NAME Wade Butler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW II	17. INFORMANT unknown	Address Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertensive cardio-vascular disease (c)								
INTERVAL BETWEEN ONSET AND DEATH 5-6 weeks								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-28 1947 to March 11 1958 . and that death occurred at 4:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 3-12-58								
ACTUAL SIGNATURE 								
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services						
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/14/58		22b. DATE THEREOF 3/14/58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PERGAMEN

MAR 18 1958

PUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 1 year		b. COUNTY Cecil	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Oleita		First -	Middle Collins	4. DATE OF DEATH 3 - 19 1958	Month 3 Day - 19 Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME no information			14. MOTHER'S MAIDEN NAME no information		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Dr. C.B.Collins Devine Nursing Home Elkton, Md	
NO		None			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R.C.Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-19-55	
EXAMINER'S NAME (Type) Dr. R.C.Dodson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-1958		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS North East, Methodist	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>				22d. LOCATION (City, town, or county) North East, Cecil Co., Md	
				(State)	
				24a. REG'D BY REGISTRAR W.L. 2	
				24b. REGISTRAR'S SIGNATURE <i>W.L. 2</i>	

NOTICE MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PW3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

BRUNSWICK

MAR 24 1955



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3176

CERTIFICATE OF DEATH

Reg. Dist. No.

03162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending-physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>309 Elkton Blvd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>J.</i>	Last <i>Pourelle</i>	4. DATE OF DEATH <i>3 24 1958</i>	Month <i>3</i>	Day <i>24</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/3/1888</i>	9. AGE (In years last birthday) yrs. <i>69</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Actor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Motion Pictures</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Wm Pourelle</i>		14. MOTHER'S MAIDEN NAME <i>Laura E. Sutton</i>		Address <i>Clark & Pourelle, Aberdeen Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16. SOCIAL SECURITY NO <i>215-32-1596</i>		17. INFORMANT <i>Clark & Pourelle, Aberdeen Md.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause lost. (b) DUE TO (c)		Acute coronary thrombosis with myocardial infarction					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>diabetes, mild</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i>					
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>March</i>	Day <i>21</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Aberdeen</i>	(County) <i>Maryland</i>
21. I certify that I attended the deceased from March 21, 1958, to March 24, 1958, that I last saw the deceased alive on March 24, 1958, and that death occurred at 8:35 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>233 E. Main Street</i>						DATE SIGNED <i>March 24, 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/27/1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Bakers Cemetery</i>		22d. LOCATION (City, town, or county) <i>Aberdeen, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Veteran J. Barron</i>		ADDRESS <i>Aberdeen, Maryland</i>		24a. REC'D. BY REGISTRAR DATE <i>MAR 31 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>	

BUREAU V. S.

MAR 31 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3193

CERTIFICATE OF DEATH

03163

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nothingham Ranch</i>		c. LENGTH OF STAY IN 1b <i>1 yr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Grayfeathers Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun Md.</i>	
3. NAME OF DECEASED (Type or print) <i>John Andrew Dollenger</i>		d. STREET ADDRESS <i>16 Haides Ave.</i>	
First <i>John</i>	Middle <i>Andrew</i>	Last <i>Dollenger</i>	4. DATE OF DEATH <i>March 26 1958</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-6-1858</i>
9. AGE (in years last birth/day) <i>99 yrs.</i>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS, Months Days Hours Min. <i>0 months 0 days 0 hours 0 min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mill-Destriker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bettired Anne Arundel Co.</i>	
10c. BIRTHPLACE (State or foreign country) <i>USA</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John A. Dollenger</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Pieper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Adolph Dollenger</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>Cardiac decompensation</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 1951, to <i>March 26</i> , 1958, that I last saw the deceased alive on <i>3/25</i> , 1958, and that death occurred at <i>4:45 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Rising Sun, Md.</i> DATE SIGNED <i>3/26/58</i>	
ACTUAL SIGNATURE <i>Neil Taylor MD</i>		PHYSICIAN'S NAME (Type) <i>Neil Taylor</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/29/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Lawn</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip Henry Son Cremat.</i>		24a. REC'D BY REGISTRAR DATE MAR 31 '58	
ADDRESS <i>2024</i>		24b. REGISTRAR'S SIGNATURE <i>All-such</i>	

BURZAU V. S.

MAR 22 1953

PEGEA Y

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3194

CERTIFICATE OF DEATH

03164

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trouml. Then please remove carbon paper. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>M.D.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>		b. COUNTY <u>CECIL</u>	
c. LENGTH OF STAY IN lb <u>100</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>		d. STREET ADDRESS <u></u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u>		First	Middle
4. SEX <u>M.</u>		5. COLOR OR RACE <u>W</u>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH <u>JULY 31, 1881</u>		8. DATE OF DEATH <u>MARCH 10, 1958</u>	
9. AGE (In years last birthday) <u>76 yrs</u>		10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL EVERETT</u>		14. MOTHER'S MAIDEN NAME <u>SARAH J. SHELTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> [Yes, no, or unknown]		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Mrs. W⁴. HAGUE,</u> Address <u>CECILTON, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> years (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
2 previous cerebro-vascular accidents		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>11 Mar</u> , 19 <u>57</u> , to <u>10 Mar</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Mar</u> , 19 <u>58</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Oberholtzer</u>		ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>12 Mar 58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MASSEY CEM.</u>		22d. LOCATION (City, town, or county) <u>MASSEY MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Stellwos, Wellington, Md.</u>		24a. REC'D BY REGISTRAR <u>D. L. Smith</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>D. L. Smith</u>	
DATE <u>MAR 14 '58</u>			

BURZAU Y. 2

ДЕГЕНЕРАЦІЯ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03165

Reg. Dist. No.

3195 Item 2 File #27 3-31-58 et

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) b. STATE Md. Indiana	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo		c. LENGTH OF STAY IN lb enroute	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 and 222		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge Fort Wayne	
3. NAME OF (Type or print) Marilyn Louise		4. DATE OF DEATH Month 3	Day Year 19 19 58
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1934
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Indiana
13. FATHER'S NAME Frank L. Fenker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 316 32 4275	17. INFORMANT Address Navy Records, NTC, Bainbridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Base of skull and neck		INTERVAL BETWEEN ONSET AND DEATH	
823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car went down an embankment 90 feet	
20c. TIME OF INJURY Month, Day, Year 11.15 3 19 58		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 1 and 222 Conowingo Cecil Md.
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED 3-21-58	
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/22/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Perryville, Md.		22d. LOCATION (City, town, or county) Fort Wayne, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Vee A. Patterson & Son</i>		24a. REC'D BY REGISTRAR Alfred E. Schaefer	24b. REGISTRAR'S SIGNATURE <i>Alfred E. Schaefer</i>
ADDRESS Perryville, Md.		DATE MAR 26 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

Bureau X's

MAR 26 1959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3196 CERTIFICATE OF DEATH

03166

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 17 yrs. 7 mo. 13 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1612 D Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Unknown					
3. NAME OF DECEASED (Type or print) CORENTH		First	Middle	Lost	4. DATE OF DEATH FITT	Month	Day	Year	March	20	19 58
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-97	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS DAYS	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Office Building		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME Robert Fitts		14. MOTHER'S MAIDEN NAME Clara (maiden name unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic heart disease DUE TO (c)		Bronchopneumonia, bilateral, unresolved				INTERVAL BETWEEN ONSET AND DEATH 5-6 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 401 x		Arteriosclerosis generalized - unknown				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that attended the deceased from August 7, 1940, to March 20, 19 58, and that death occurred at 4:20 a.m. from the causes and on the date stated above ACTUAL SIGNATURE <i>S. P. Lacerva</i> M.D. V.A. Hospital, Perry Point, Md. 3-21-58						ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-25-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Pennington & Son</i>		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE <i>Allen</i>					

BUREAU V. S

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03167

3177

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle B.	Last Foard
4. DATE OF DEATH	Month March	Day 19	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 31, 1874
9. AGE (in years last birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store-keeper	11. KIND OF BUSINESS OR INDUSTRY General	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Eli J. Foard	14. MOTHER'S MAIDEN NAME Mary E. Billney	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Adelaide W. Foard	Address Chesapeake City Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYOCARDITIS DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH ONE WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) .	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) .	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 16, 1958 , to March 19, 1958 , that I last saw the deceased alive on March 19, 1958 , and that death occurred at 11:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry Davis</i> M.D.	ADDRESS (Street, city or town, state) Chesapeake City Md. DATE SIGNED 3/20/58		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS In Elkton, Md.	
		24a. REC'D BY REGISTRAR W.W. Lee	24b. REGISTRAR'S SIGNATURE W.W. Lee
		DATE Mar 26 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURKAU X. S

MAR 26 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Medical Examiner's Certificate of Death

03168

3197

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, R.D.		b. COUNTY Cecil	
c. LENGTH OF STAY IN ID All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun R.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry Jimson Fox		First Harry	Middle Jimson
4. DATE OF DEATH 3 20 1958	Month 3	Doy 20	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-1906
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Rising Sun, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter S. Fox		14. MOTHER'S MAIDEN NAME Ely McCallough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-34-6888	
17. INFORMANT Mrs. Virginia Fox, Rising Sun, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Back and Chest.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Porch roof collapsed and fell on him.	
20c. TIME OF INJURY Month, Day, Year Hour 8:00 a.m. 3 20, 58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Rising Sun R.D. Cecil		(County) Md.	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 3-22-58	
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-58	
22c. NAME OF CEMETERY OR CREMATORIAL Rosebank		22d. LOCATION (City, town, or county) Calvert Cecil Co. Md	
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE Mar 26 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE A.W. Hedrich	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03169

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

Item 14, Film G-222 4/10/58, cac		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 30 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 123 Singerly Ave.	
3. NAME OF DECEASED (Type or print) William H. Fox, Sr.		4. DATE OF DEATH	Month Day Year
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11-15-1897 9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor & Builder		10b. KIND OF BUSINESS OR INDUSTRY All building	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Fox		14. MOTHER'S MAIDEN NAME Mary McCleary Angeline Houck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-0763 17. INFORMANT Mrs. Wm. H. Fox, 123 Singerly Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gove rise to immediate cause (b) Pulmonary Hemorrhage (c)			
(d) Extreme Arteriosclerosis DUE TO (e)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <i>R.C. Dodson</i> EXAMINER'S NAME (Type) R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Elverson Meth. Cemetery Elverson Penna. 22d. LOCATION (City, town, or county) Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i> VS. A15ME(5) 5M 9/55		ADDRESS Elkton, Md. 24a. REC'D BY REGISTRAR REC'D 13 58 24b. REGISTRAR'S SIGNATURE <i>John J. ~ ~</i>	

TRAU V. E

MAR 13 1929

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03170

Reg. Dist. No.

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DEPUTY MEDICAL DIRECTOR: This certificate, writing the word "pending" in pencil in item 1B, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 W. Main St.		e. STREET ADDRESS 225 W. Main St.	
3. NAME OF DECEASED (Type or print) Ralph Edward Garrett		4. DATE OF DEATH Month Day Year Hour o. m. p. m. 3 30 1958	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-20-1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Eng		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
10c. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes		14. MOTHER'S MAIDEN NAME Lucy J. Spittle	
15. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		16. DUE TO: (b) 	
17. DUE TO: (c) 		18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 	
19. WAS AUTOPSY PERFORMED? NO		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> R. C. Dodson		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton Cemetery	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		24. DATE THEREOF 4/2/58	
25. ADDRESS Elkton, Md.		26. LOCATION (City, town, or county) Elkton, Maryland	
27. REC'D BY REGISTRAR APR 2 '58		28. REGISTRAR'S SIGNATURE Ralph E. Hicks	

BUREAU V.

4458

REVIEWED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03171

3198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Annie	Middle Nancy	Lost Goodnow	4. DATE OF DEATH March	Month 1	Day 1958	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1886	9. AGE (in years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Margaret Bennett						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT None		Address Delbert R. Goodnow North East, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Renal Disease</u> <u>40 yrs.</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)								
DUE TO								
DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Calcific Cholecystitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>7/27</u> , 19 <u>56</u> , to <u>1 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 March</u> , 19 <u>58</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D.						ADDRESS (Street, city or town, state) <u>North E. 1 Rd</u>		
PHYSICIAN'S NAME (Type)						DATE SIGNED <u>3 Mar. 6 '58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-58		22c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery		22d. LOCATION (City, town, or county) North East, Cecil Co. Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Grant</u>		ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE MAR 6 '58		24b. REGISTRAR'S SIGNATURE <u>John J. Gage</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 19

REGISTRATION
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03172

3180

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN lb <i>10 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Rd 4 Elkton</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>MARTHA P. GRADEN</i>		First	Middle	Last	4. DATE OF DEATH <i>3 2 1958</i>	Month	Day	Year					
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-1884</i>	9. AGE (in years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS. Days <i>2</i>	Hours <i>1958</i>	Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Chicago Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Charles Wheelock</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Palmer</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>197-12-653B</i>		17. INFORMANT <i>John Robert Granden</i>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>400.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>Coronary Arteries Thrombosis</i> <i>(c)</i> DUE TO <i>Coronary Arteries Sclerosis</i>		ACUTE CORONARY Occlusion		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>100.8 DIABETES MELLITUS, Acidosis</i>		CORONARY ARTERIES Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m.				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>154 W Main</i>		20f. (City or town) (County) <i>Elkton</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>2-21-1958</i> to <i>3-2-1958</i> , that I last saw the deceased alive on <i>3-1-58</i> , and that death occurred at <i>447 1/2 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Peter Stavros</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>PETER STAVRAKIS M.D. ELKTON, Md.</i> DATE SIGNED <i>3-2-58</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-4-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Elkton Cemetery</i>	22d. LOCATION (City, town, or county) <i>Elkton</i> (State) <i>Md.</i>										
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter duBois Jr.</i>		ADDRESS <i>Elkton, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>Mar 6 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Dick, such</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 6 1938



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3181 CERTIFICATE OF DEATH

03173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton		d. STREET ADDRESS R.F.D-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julius		First	Middle	Last	4. DATE OF DEATH Green	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1893	9. AGE (in years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Richard T. Green		14. MOTHER'S MAIDEN NAME Clara Rodgers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Irvin Green-953 Ellicott Dr. Balt. Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		massive myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 3 min			
(b)		DUE TO		Coronary occlusion		7 min			
(c)				Atherosclerotic Heart Disease		years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bohemian Manor, Md.		(County)	(State)
21. I certify that I attended the deceased from Mar 22, 1958 to Mar 25, 1958 , that I last saw the deceased alive on Mar 25, 1958 , and that death occurred at 9:28 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Bohemian Manor, Md.	
ACTUAL SIGNATURE Wallace Oberhauer		DATE SIGNED 3-28-58							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/58		22c. NAME OF CEMETERY OR CREMATORIAL Bohemia Manor Cem.		22d. LOCATION (City, town, or county) Bohemia Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Bell		ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE 3/28/58		24b. REGISTRAR'S SIGNATURE John R. Bell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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BUREAU V. S.

MAR 1 1973

REGISTRATION
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03174

3199

CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. LENGTH OF STAY IN lb 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Bainbridge, Maryland				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge			
3. NAME OF DECEASED (Type or print) Mary				First Mary	Middle Patricia	Last Hayes	4. DATE OF DEATH Month March Day 6 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH March 5, 1958	9. AGE (in years last birthday) yr. 1	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Bainbridge, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas T. Hayes				14. MOTHER'S MAIDEN NAME Laura Mae Sinclair			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT Thomas T. Hayes Address Bldg. 910 Apt. #3, Bainbridge Village, Bainbridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature, neonatal				INTERVAL BETWEEN ONSET AND DEATH 1 day			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 							
DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Colona	20f. (City or town) Colona	(County) Colona (State) Colona
21. I certify that I attended the deceased from 5 March 1958 , to 6 March 1958 , that I last saw the deceased alive on 6 March 1958 , and that death occurred at 0435 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 6 March 1958							
ACTUAL SIGNATURE Allen P. Hartman, M.D.							
PHYSICIAN'S NAME (Type) ALLEN P. HARTMAN, M.D. Physician's Name (Type) ALLEN P. HARTMAN, M.D. ADDRESS Bainbridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7 March 1958	22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cemetery	22d. LOCATION (City, town, or county) Colona	(State) Colona			
23. FUNERAL DIRECTOR'S SIGNATURE Vella Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR Mar 7 '58	24b. REGISTRAR'S SIGNATURE Webber		
I, the undersigned, declare that I was not present at the time of death.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BULAU V. S.

87 129

LEADERS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3200

CERTIFICATE OF DEATH

03175

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
f. STREET ADDRESS <u>Geo. & Third Sts</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY E. Howard</u>		4. DATE OF DEATH <u>March 3 1958</u>	Month Day Year
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William P. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth boulden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Evelyn H. Davis Chesapeake City, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <u>1955</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u>			
450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 5, 1955</u> to <u>MARCH 3, 1958</u> that I last saw the deceased alive on <u>MARCH 3, 1958</u> , and that death occurred at <u>11:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry Davis M.D.</u>		ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY MD</u>	
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS</u>		DATE SIGNED <u>3/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-1958</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>ELKTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON, CECIL C. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>North East Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albertine</u>	

BURTON V. E.

MAR 7 1923

LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3201

CERTIFICATE OF DEATH

03176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN lb 26 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First John	Middle Randolph	Last Janney Sr.	4. DATE OF DEATH Month March	Day 22	Year 1958	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1866	9. AGE (in years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months 91	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Train Master		10b. KIND OF BUSINESS OR INDUSTRY Penna R.R. Ret		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Janney of Eli		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Mahoney		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT John Randolph Janney Jr.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4241 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Myocarditis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)	
21. I certify that I attended the deceased from June , 19 57 , to March 22 , 19 58 , that I last saw the deceased alive on March 21 , 19 58 , and that death occurred at 6:00 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>D H Richards</i>	ADDRESS (Street, city or town, state) 100 E. Charles St., Baltimore, Md 21202						DATE SIGNED Mar 26 1958	
PHYSICIAN'S NAME (Type) G H RICHARDS Jr.	M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-26-1958	22c. NAME OF CEMETERY OR CREMATORIAL Bay View Methodist			22d. LOCATION (City, town, or county) Rural	(State) North East Cecil Co., Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>			ADDRESS Joseph R. Grant North East, Maryland	24a. REC'D. BY REGISTRAR Mar 26 1958		24b. REGISTRAR'S SIGNATURE <i>W. H. Richards</i>	DATE Mar 26 1958	

BURKAU Y, E

MAR 26 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3202

CERTIFICATE OF DEATH

03177

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle H.	Last JONES
4. DATE OF DEATH	Month 3	Day 8	Year 19 58
S. SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-15-93
9 AGE (In years lost birthday) 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None
10c. BIRTHPLACE (State or foreign country) St. Augustine, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MOSE JONES		14. MOTHER'S MAIDEN NAME JANIE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 219 01 4827	
17. INFORMANT HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral, unresolved DUE TO 177X		INTERVAL BETWEEN ONSET AND DEATH 5 to 6 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of prostate, widespread DUE TO metastasis to abdominal & chest cavities & lymph nodes (c) Arteriosclerosis, generalized, severe		Unk.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 471X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-3- , 19 58 to 3-8- , 19 58 , and death occurred at 8:44 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) EDWARD BELL FUNERAL HOME, Wilmington, Del. DATE SIGNED 3-9-58			
ACTUAL SIGNATURE Joseph Grasberger M.D. VA Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) JOSEPH GRASBERGER, M.D., Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/12/58	22c. NAME OF CEMETERY OR CEMINATORY Bohemian Manor	22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bell	ADDRESS EDWARD BELL FUNERAL HOME, Wilmington, Del.	24a. REC'D BY REGISTRAR Datesuch	24b. REGISTRAR'S SIGNATURE A. Datesuch
DATE MAR 11 '58		DATE MAR 11 '58	

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNEAU V.

MAR 11 1958

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3203

CERTIFICATE OF DEATH

03178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colora</i>	c. LENGTH OF STAY IN 1b <i>70 yrs.</i>	b. COUNTY <i>Cecil</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colora</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <i>William Thomas Keetley</i>		4. DATE OF DEATH <i>3 - 6 - 1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-16-1885</i>		
9. AGE (In years lost birthday) <i>73 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Hand</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	12. BIRTHPLACE (State or foreign country) <i>Chester Co. Penn</i>		
13. FATHER'S NAME <i>William Keetley</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Terry</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>111-11-1111</i>	17. INFORMANT <i>Mrs Elizabeth Keetley Colora Md.</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of stomach & metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Colora</i>	20f. (City or town) <i>Colora</i>	(County) <i>Colora</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>the 10 1958</i> to <i>6 - 1958</i> , that I last saw the deceased alive on <i>3-5-1958</i> , and that death occurred at <i>5:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>D. Richards</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>G.H. Richards M.D. Post Deposit Md.</i> DATE SIGNED <i>3-8-58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-10-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Buckley Cem.</i>	22d. LOCATION (City, town, or county) <i>Rising Sun Md.</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lemon E. McPherson Rising Sun</i>	ADDRESS <i>101 Main Street</i>	24a. REG'D BY REGISTRAR <i>MARTI 58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Maden</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

133

BUREAU V. 2

03179

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 20 min.		d. STATE Maryland b. COUNTY Cecil	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. 3.		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William		First Weldon	Middle Kent	4. DATE OF DEATH 3 13 1958	Month 3 Day 13 Year 1958
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 6-3-1923 9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Months 3 Days 13 Hours 00 Min. 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Auto. Gen Motors		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME William W. Kent.		14. MOTHER'S MAIDEN NAME Alice Hurd		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 221-12-8512		17. INFORMANT Mrs. William W. Kent, Elkton, R.D. 3, Md.	
Address				INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion					
44-0-1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED <i>3-13-58</i>			
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Elkton Cemetery	
22d. LOCATION (City, town, or county) Elkton, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR MAR 17 '58	
				24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

BUREAU V. E.

MA 17 1958

REGELIA EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03180

3204 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adrian					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1004 Treat Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Jackline	Middle Ann	Last Lewis	4. DATE OF DEATH March 28, 1958	Month March	Day 28	Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1957		9. AGE (In years lost birthday) 1 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Adrian, Michigan		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Dan Richard Lewis				14. MOTHER'S MAIDEN NAME Marilyn Herd					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Marilyn Lewis 1004 Treat St., Adrian Michigan		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 482X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 28 Nov. 1957								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 28 Nov. 1957, to 28 March, 1958, that I last saw the deceased alive on 28 Nov. 1957, and that death occurred at 11 P. M., from the causes and on the date stated above. ACTUAL SIGNATURE Klaus H. Heuer M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Klaus H. Heuer, Jr. DATE SIGNED 29 Mar. 1958									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-29-58		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Adrian, Michigan (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE A. L. Seach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reproduced by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director: page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTEAU M.

1959

MONTEAU

B
D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3205 CERTIFICATE OF DEATH

03181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First James	Middle Finney	Last Magraw	4. DATE OF DEATH Month March Day 27 Year 19 58
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1887	9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Dr. James M. Magraw			14. MOTHER'S MAIDEN NAME Katherine Stump		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna D. Magraw, Perryville, Maryland	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro - Vascular accident INTERVAL BETWEEN ONSET AND DEATH 7 wks.					
443A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis, hypotension 8 yrs DUE TO (c) Anterior sclerosis 10 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1951 , to March 29, 1958 , that I last saw the deceased alive on March 26, 1958 , and that death occurred at 4:30 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>G. H. Richards, Jr., M.D.</i>			ADDRESS (Street, city or town, state) B. H. Hospital, Md. 3/27/58 DATE SIGNED		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/58		22c. NAME OF CEMETERY OR CREMATORIAL W. Nottingham Cemetery	
22d. LOCATION (City, town, or county) Colora, Cecil Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Keva Patterson, Jr.</i>		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE MAR 31 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

SCOTT V. S.

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PLATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03182
3206 CERTIFICATE OF DEATH										Reg. Dist. No. 96
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferry Point		c. LENGTH OF STAY IN lb 18 yrs. 6 mo.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roland Park, Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					d. STREET ADDRESS 4605 Wilmslow Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First JOEL	Middle W.	Last MASSIE	4. DATE OF DEATH	Month March	Day 7	Year 1958		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1894	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Private Practice		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME Patrick C. Massie					14. MOTHER'S MAIDEN NAME Elizabeth Kirkman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT unknown		Address Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 3 days										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO 20 yrs.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 491X YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from September 8, 1958, to March 7, 1958, and that death occurred at 1:55 AM, from the causes and on the date stated above ACTUAL SIGNATURE Joseph Grasberger M.D. V.A. Hospital, Perry Point, Md. 3-7-58 PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D. Acting Director, Professional Services										
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-8-58		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Va.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons Havre de Grace, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 11 '58		24b. REGISTRAR'S SIGNATURE John A. Buscher				

RECEIVED
MAR 11 1968

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03183

3207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Norman	Middle H.	Last McMullen	4. DATE OF DEATH	Month March	Day 24	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/5/79	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY County School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Hazlett McMullen				14. MOTHER'S MAIDEN NAME Mary Smith				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Kathryn S. McMullen, Perryville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		<i>Cervical Vascular Accident</i>					INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>400.2</i>		<i>Myocarditis</i>					DUE TO 5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first. (b) <i>Myocarditis</i>							DUE TO 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. p.m.	Month April	Day 23	Year 1958	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Perryville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from April 23, 1958 , to April 24, 1958 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>G. H. Richards, Jr., M.D.</i>							ADDRESS (Street, city or town, state) Perryville, Md.	DATE SIGNED 3/26/58
PHYSICIAN'S NAME (Type)		G. H. Richards, Jr., M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Mark's Cemetery			22d. LOCATION (City, town, or county) Perryville Rural Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leila Patterson & Son, Perryville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE Mar 27 '58		24b. REGISTRAR'S SIGNATURE <i>Leila Patterson & Son</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03184

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 8mos. 13days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 2638 St. Benedict Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHRISTIAN		First	Middle	Lost	4. DATE OF DEATH March 30 1958	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 12-25-1908	10. AGE (In years lost birthday) 49 yrs	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS Days	13. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FRED B. MILLIGAN				14. MOTHER'S MAIDEN NAME MARY BAKER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW-II 265-07-4667		17. INFORMANT Hospital Records, VA Hosp., Perry Point, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema pulmonary acute, due to remote trauma INTERVAL BETWEEN ONSET AND DEATH 6-8 hours 191.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Surgical removal of the right shoulder girdle 3-28-58 DUE TO (c) Recurrent epidermoid carcinoma of the skin, right shoulder unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that ✓ attended the deceased from July 17, 1957, to March 30, 1958 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>S. P. Lacerva</i>		ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 3-31-58						
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services						
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/3/58		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cunningham</i>		ADDRESS PENNICKSON & SON, Havre DeGrace, Md.		24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE <i>Alt. Leach</i>		

BUREAU U. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3183

03185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 36 hrs					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Baby Girl	Middle 	Last Moore	4. DATE OF DEATH March 17, 1958	Month March	Day 19	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1958		9. AGE (In years lost birthday) yrs 0	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 36	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Robert Lee Moore			14. MOTHER'S MAIDEN NAME Ann Umberger						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Robert Lee Moore North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Premature infant - 2 lbs 3 oz. 11/14 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Premature labor - cause undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (b) DUE TO (c)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 							
20c. TIME OF INJURY Month, Day, Year Hour o.m. — 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 	(State)
21. I certify that I attended the deceased from 17 March, 1958 , to 19 March, 1958 , that I last saw the deceased alive on 19 March, 1958 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Klaus H. Huchner					ADDRESS (Street, city or town, state) North East, Md.				DATE SIGNED 19 March '58
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/58		22c. NAME OF CEMETERY OR CREMATORIAL North East Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Giant		ADDRESS North East, Md.		24a. REC'D BY REGISTRAR MAR 24 '58		24b. REGISTRAR'S SIGNATURE Alvarez			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURGESS V. S.

MAR 24 1973

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3209

CERTIFICATE OF DEATH

03186

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate been signed by the attending physician and completely filled in, he should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Earleville		c. LENGTH OF STAY IN lb 15 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md		b. COUNTY Cecil	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Earleville			
3. NAME OF DECEASED (Type or print)		First Sarah	Middle Jane	Last Moore	4. DATE OF DEATH March 4, 1958	Month March	Day 4	Year 1958	a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1870		9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Samuel Hurd				14. MOTHER'S MAIDEN NAME Marth Bailey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <small>If yes, give war or date of service)</small>		16. SOCIAL SECURITY NO. none		17. INFORMANT George W. Moore Earleville Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral thrombosis							
DUE TO									
Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause lost: (b)		Cerebral Arteriosclerosis							
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Diabetes Mellitus									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I attended the deceased from Jan 25, 1958, to Mar 4, 1958, that I last saw the deceased alive on Mar 4, 1958, and that death occurred at _____ M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Wallace Oberlein</i>				ADDRESS (Street, city or town, state) Cecilton, Md.				DATE SIGNED 5 Mar 58	
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 7, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Galena Cem.		22d. LOCATION (City, town, or county) Galena		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Ellsworth Melville, Jr.</i>		ADDRESS <i>1000 N. Charles St., Baltimore, Md.</i>		24a. REC'D BY REGISTRAR DATE MAR 10 '58		24b. REGISTRAR'S SIGNATURE <i>Archibald</i>			

S. A. U. V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3184

CERTIFICATE OF DEATH

03187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) Helen Hindman		First Helen	Middle Piner
4. DATE OF DEATH March 12 1958		Last March	Month Day Year
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1902
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months 117	11. IF UNDER 24 HRS. Days Milbourn St.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Elkton, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Hindman		14. MOTHER'S MAIDEN NAME Annie Congo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Hattie Hindman
			117 Milbourn St. Elkton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE INTERVAL BETWEEN ONSET AND DEATH 1 day			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR SCLEROSIS 2-3 years			
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-11 , 19 58 , to 3-12 , 19 58 , that I last saw the deceased alive on 3-12 , 19 58 , and that death occurred at 154 W. MAIN M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED PETER STAVRAKIS M.D. ELKTON, MD 3-14-58.			
ACTUAL SIGNATURE Peter Stavakis		PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D. ELKTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15-1958	22c. NAME OF CEMETERY OR CREMATORIAL Providence Methodist
22d. LOCATION (City, town, or county) Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Dennis General H. & Son		24b. REGISTRAR'S SIGNATURE D. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3185

CERTIFICATE OF DEATH

03188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY Cecil		
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 103 Locust Lane		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Grace Wells Price	First Grace	Middle Wells	Last Price	
4. DATE OF DEATH March 25, 1958	Month March	Day 25	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1891	
9. AGE (in years last birthday) 67 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 0	Days 0	Hours 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher	10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank P. Price	14. MOTHER'S MAIDEN NAME Ella Cantwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-20-1252	17. INFORMANT Mrs. Grace Price Zogbaum	Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe upper respiratory virus infection 1 month ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	Month Feb.	Day 18	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Elkton	(County) Maryland	(State) Md.	
21. I certify that I attended the deceased from Feb. 18, 1958 to March 25, 1958 , that I last saw the deceased alive on March 25, 1958 , and that death occurred at 9:40 a.m. from the causes and on the date stated above. ACTUAL SIGNATURE Ralph Andrews, Jr.				
ADDRESS (Street, city or town, state) 235 E. Main Street DATE SIGNED March 25, 1958				
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 29, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Elkton Cemetery	22d. LOCATION (City, town, or county) Elkton (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home	ADDRESS 103 Locust Lane Elkton, Md.	24a. REC'D BY REGISTRAR DATE MAR 31 '58	24b. REGISTRAR'S SIGNATURE John G. Lee	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUKLAU V. S.

3. 31. 1958

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

83189

CERTIFICATE OF DEATH

Reg. Dist. No.

3210

PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Md.

b. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rising Sun Rural

c. LENGTH OF STAY IN lb

3 Weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Charlestown Rural

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Graybeal Nursing Home

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
CharlesMiddle
HerbertLast
Rogers4. DATE
OF
DEATHMonth
MarchDay
30Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
77 yrs.10. IF UNDER 1 YEAR
IF UNDER 24 HRS.Months
Days
Hours
Min.

Male

White

WIDOWED DIVORCED

April 24 1880

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Retired

Steamship Captain

Nova Scotia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Rogers

14. MOTHER'S MAIDEN NAME

Sara Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES, OR UNKNOWN
 NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

None

Mrs. Joseph Santiago

204 Ridge Ave.
Towson 4 Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Chronic Hypertension

INTERVAL BETWEEN
ONSET AND DEATH

443X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b) Hypertension and Arteriosclerosis

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month

Day

Year

Hour

o. m.

19

p. m.

White Not white
of work of work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 3-25-58, 19, to 3-30-58, 19, that I last saw the deceased
alive on 3-25-58, 19, and that death occurred at M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURER. C. Seddon
M.D.

Rising Sun, Md.

3-31-58

PHYSICIAN'S
NAME (Type)

R. C. Seddon

M.D.

Rising Sun, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

Burial

April 2 1958

West Nottingham

Near Colora, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
DATE APR 2 '5824b. REGISTRAR'S SIGNATURE
Allen couch

BUREAU N.Y.

29 3 1922

REGELVET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3186 CERTIFICATE OF DEATH

03190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EARLEVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) UNION HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT BRUCE RONIG	First	Middle	Last
4. DATE OF DEATH MAR. 10 1958	Month	Day	Year
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1957
9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY		10b. KIND OF BUSINESS OR INDUSTRY ELKTON, MD.	
10c. BIRTHPLACE (State or foreign country) ELKTON, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. RONIG		14. MOTHER'S MAIDEN NAME SARAH E. POTTER.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. KANE	
17. INFORMANT MRS. GEORGE RONIG-EARLEVILLE, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTUSSECUSION OF ILEUM 750.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANTRALIC DIVERTICULUM (c) GANGRENE OF ILEUM		36 HOURS	
LIFE		12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 8, 1958 to MAR 10, 1958, that I last saw the deceased alive on MARCH 10, 1958, and that death occurred at 7:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS SIGNED ACTUAL SIGNATURE M.D. 3/10/58			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS		DATE SIGNED 3/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/12/58	
22c. NAME OF CEMETERY OR CREMATORIUM WHITE CHAPEL GARDENS, FEASTERVILLE, PA.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows, Wellington, Md.		24a. REC'D BY REGISTRAR MAR 14 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X.

2-59

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3187

CERTIFICATE OF DEATH

03191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Russell	4. DATE OF DEATH Month March Day 18 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Windell		14. MOTHER'S MAIDEN NAME No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. John Zahn Nr. Elkton, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH unknown	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Herpes zoster		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day Year Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 17, 1956 , to March 18, 1958 , that I last saw the deceased alive on March 17, 1958 , and that death occurred at 9:15 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 3/19/58			
ACTUAL SIGNATURE <i>S. Ralph Andrews Jr.</i>		PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 22, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Elkton Cemetery		22d. LOCATION (City, town, or county) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		24a. REC'D BY REGISTRAR DATE MAR 26 '58	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE John M. De	

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURKAU V. S

MAR 1 1955

PEREGRINE

TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. If institution: Residence before admission
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A1S (4)
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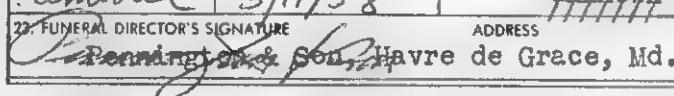
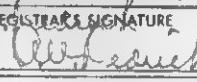
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Form 274-15-58 et

Q3192
 96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		b. COUNTY Pike	
c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushkill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELLEN	Middle E.	Last SANDERSON
4. DATE OF DEATH	Month March	Day 9	Year 19 58
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-74
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Phillipsburg, N. J.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Sanderson		14. MOTHER'S MAIDEN NAME Lydia Jane Lynd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW I	17. INFORMANT Hospital Records, VAH, Perry Point, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, massive, gastro-intestinal		INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Cirrhosis of the liver		unknown	
DUE TO Arteriosclerotic heart disease		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized, severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fairmount
20f. (City or town) Marlinton		(County) Montgomery	
		(State) MD	
21. I certify that I attended the deceased from March 5, 1958 , to March 9, 1958 , and that death occurred at 8:55 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Marlinton, New Jersey	
ACTUAL SIGNATURE 		DATE SIGNED 3-10-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/11/58	22c. NAME OF CEMETERY OR CREMATORIUM unknown Fairmount
22d. LOCATION (City, town, or county) Marlinton		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE 		24a. ADDRESS Havre de Grace, Md.	24b. RECEIVED BY REGISTRAR MAR 17 '58
		REGISTRAR'S SIGNATURE 	
		DATE	

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MAR 17 1968

REGELAED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03193

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 21 Film 22 1-2-50			
1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b 47 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vincenzo		First	Middle
			Sellare
4. DATE OF DEATH March 26	Month	Day	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman		10b. KIND OF BUSINESS OR INDUSTRY Penna. Railroad	11. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME Joseph Sellare		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 717-07-5380	17. INFORMANT Mrs. Antoinette V. Sellare, Perryville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 5, 1957</u> , to <u>March 26, 1958</u> , that I last saw the deceased alive on <u>March 26, 1958</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Berlene Johnson</i>	M.D.	ADDRESS (Street, city or town, state) <i>Port Deposit, Md.</i>	DATE SIGNED <i>3/27/58</i>
PHYSICIAN'S NAME (Type)		Maryland —	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/29/58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Erin Cemetery	22d. LOCATION (City, town, or county) (State) Havre de Grace, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kee Patterson & Son, Perryville, Md.</i>	ADDRESS	24a. RECD BY REGISTRAR DATE MAR 31 '58	24b. REGISTRAR'S SIGNATURE <i>Abel Leach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be rechecked by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUKAVU Y. S

AR 31 1900

REGIMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 227 4-8-58 ams

03194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Perry	Middle Henry
		Last Sewell	4. DATE OF DEATH Month March
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Harriett Sewell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 219-20-8916		17. INFORMANT Edna G. Sewell-Chesapeake City, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Interstitial Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia Poison DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Years 2 Months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 12, 1957, to March 23, 1958, that I last saw the deceased alive on March 18, 1958, and that death occurred at 5:13 A.M., from the causes and on the date stated above		ADDRESS (Street, city or town, state) Elkton, Maryland DATE SIGNED 3/24/58	
ACTUAL SIGNATURE James L. Johnson PHYSICIAN'S NAME (Type) James L. Johnson M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3/29/58		22c. NAME OF CEMETERY OR CREMATORIUM Bohemia Manor Cem.	22d. LOCATION (City, town, or county) Bohemia Manor, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Cliff R. Bell		24a. REC'D BY REGISTRAR DATE 3/24/58	24b. REGISTRAR'S SIGNATURE Rebecca

LAU Y.

1929

LAU Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3214

CERTIFICATE OF DEATH

Reg. Dist. No. 03195

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Conowingo</i>	c. LENGTH OF STAY IN 1b <i>life</i>	b. COUNTY <i>Cecil</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	d. STREET ADDRESS <i>Rural - Conowingo</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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3. NAME OF DECEASED (Type or print)	First <i>Virginia Elizabeth Taylor</i>	Middle <i></i>	Last <i></i>	4. DATE OF DEATH <i>3 - 4 - 1958</i>	Month <i></i>	Day <i></i>	Year <i></i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-23-1884</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months <i></i>	Days <i></i>	Hours <i></i>	Min <i></i>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Cecil Co. Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Strawbridge</i>	14. MOTHER'S MAIDEN NAME <i>Gerry</i>	Elisabeth Virginia Fisher
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>219-01-66058</i>	17. INFORMANT <i>Horace W. Taylor Conowingo, Md.</i>	Address <i></i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH <i>89 days</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer - Tongue</i>	DUE TO <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i>	DUE TO <i></i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>Jene</i> , 19 <i>57</i> , to <i>Mar 5</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3 - 1</i> , 19 <i>58</i> , and that death occurred at <i>1:40 PM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>West Nottingham, Cecil County, Maryland</i>	DATE SIGNED <i>Mar 7 1958</i>
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ACTUAL SIGNATURE <i>J. H. Richardson Jr.</i>	M.D.
PHYSICIAN'S NAME (Type) <i>James E. McMillan</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-8-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>West Nottingham Cemetery, Maryland</i>	22d. LOCATION (City, town, or county) (State) <i>West Nottingham, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. McMillan, Rising Sun, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>Mar 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>

BUREAU Y.

JAN 7 1968



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3215

CERTIFICATE OF DEATH

03196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa.		b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rising Sun		c. LENGTH OF STAY IN 1b 6 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chathan, Pa.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Conv. Home				d. STREET ADDRESS Route 41		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Gurney	Middle P.	Last Tingley	4. DATE OF DEATH March 12, 1958	Month March	Day 12	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agricultural farm		11. BIRTHPLACE (State or foreign country) New London, Ches. Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Lamont Tingley		14. MOTHER'S MAIDEN NAME Emily Worrall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Worrall Tingley, Chatham, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastric Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rising Sun, Md.	(County) Frederick	(State) Md.	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 3-12-58	
ACTUAL SIGNATURE <i>R. C. Dodson</i>			M.D.		Rising Sun, Md.		
PHYSICIAN'S NAME (Type) R. C. Dodson, M.D.						Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Faggs Manor Cemetery	22d. LOCATION (City, town, or county) Chester County, Pa.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Carl Tyson</i>		ADDRESS Rising Sun, Md.	24a. REC'D BY REGISTRAR DATE MAR 17 '58	24b. REGISTRAR'S SIGNATURE <i>u</i>			

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEMBER V. S

MAR 13 1959

DECEMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3216

CERTIFICATE OF DEATH

Reg. Dist. No.

03197
96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Delaware		b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 12 yrs 4 mo 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington		d. STREET ADDRESS 3 E. 3rd St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF STAFF (Type or print)	First WILLARD	Middle R.	Last TONLINSON	4. DATE OF DEATH Month March	Day 15	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months 6	Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Wilmington, Del.			
13. FATHER'S NAME Harry Tomlinson				14. MOTHER'S MARRIED NAME Anna Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho - pneumonia				INTERVAL BETWEEN ONSET AND DEATH 12 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 441A (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with CNS syphilis.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) VA					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wilmington		(County) Delaware	(State) Delaware
21. I certify that I attended the deceased from 11-6 , 1945, to 3-15 , 1958, and that death occurred at 3:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-15-58							
DATE SIGNED							
ACTUAL SIGNATURE E. S. Ellis, M.D.							
PHYSICIAN'S NAME (Type) Acting Director Professional Services, VAH, Perry Point, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/58	22c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery	22d. LOCATION (City, town, or county) Wilmington, Delaware	(State) Delaware			
23. FUNERAL DIRECTOR'S SIGNATURE Albert J. McCay		ADDRESS 2700 Wash St. Wilmington, Del.	24a. REC'D BY REGISTRAR A. L. Evans	24b. REGISTRAR'S SIGNATURE A. L. Evans			
DATE MAR 18 '58							

RECEIVED
BUREAU V. S.

MAR 18 1963

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

03198
Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cecilton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH Month 3 Day 2 Year 1958
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH 5-15-1942	9. AGE (In years last birthday 15 yr.)	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Elkton, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Herbert Evan Wesley			14. MOTHER'S MAIDEN NAME Pear Wilson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		
17. INFORMANT Pearl Wesley, Cecilton, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another boy					
20c. TIME OF INJURY Month, Day, Year Hour <u>XXX</u> <u>11:10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building	
(County) Cecil		(State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		DATE SIGNED 3/3/58			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Griffin Cemetery	
22d. LOCATION (City, town, or county) Cedar Hill, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Bell</u>		24a. REC'D BY REGISTRAR DATE MAR 5 '58		24b. REGISTRAR'S SIGNATURE <u>John Bell</u>	

W. A. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03199

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Md.		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Charlestown Gravel Bank		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) F. Grady		First Frank	Middle Williams
4. DATE OF DEATH 3-15-1958		Last Williams	Month Day Year 3 15 1958
5. SEX M		6. COLOR OR HAIR W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-28-1898		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attende V.A. Hosp.		10b. KIND OF BUSINESS OR INDUSTRY V.A. Hospital	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mac Williams		14. MOTHER'S MAIDEN NAME Sara Rebecca All	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 217-18-6449	
		17. INFORMANT Mrs. Bessie Williams, Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Penetrating bullet wound in left side of forehead			
DUE TO 910x			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) with loss of brain tissue			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 32 caliber revolver	
20c. TIME OF INJURY Month, Day, Year Hour 2 p.m. 3 15 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gravel Bank	
20f. (City or town) Perryville, Md.		(County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dedmon		DATE SIGNED 3-17-58	
EXAMINER'S NAME (Type) R.C. Dedmon		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-1958	
22c. NAME OF CEMETERY OR CREMATORIUM Principio Cemetery		22d. LOCATION (City, town, or county) Principio Furnace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Lattner, Jr., glod,		ADDRESS Perryville, Md.	
		24a. REC'D BY REGISTRAR DATE MAR 19 '58	
		24b. REGISTRAR'S SIGNATURE Alv. Smith	

Y. S.
LAU

MAR 21 1975

DEPARTMENT OF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3189

CERTIFICATE OF DEATH

Reg. Dist. No. 03200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE M.D.		b. COUNTY CECIL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CECILTON		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WALTER		First	Middle	Last	4. DATE OF DEATH MARCH 20 1958	Month	Day	Year
5. SEX M.		6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR <input type="checkbox"/> yrs.	IF UNDER 24 HRS. <input type="checkbox"/> Months	Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABOR		10b. KIND OF BUSINESS OR INDUSTRY LABORER		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME LIZZIE BROWN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT HENRIETTA WILMER		Address CECILTON, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 24 days		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic Heart Disease						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	Generalized Arteriosclerosis		5 yrs.			
		(c)			?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) North East, Md.	(County) MD.	(State)
21. I certify that I attended the deceased from 2/19 , 1958, to 3/20 , 1958, that I last saw the deceased alive on 19 March , 1958, and that death occurred at 9:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) North East, Md.		
ACTUAL SIGNATURE Klaus H. Huchner		M.D.				DATE SIGNED 21 March '58		
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/24/58		22c. NAME OF CEMETERY OR CREMATORIAL CECILTON CO. CEM.		22d. LOCATION (City, town, or county) CECILTON		(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Wellington, Md.		ADDRESS Wellington, Md.		24a. REC'D BY REGISTRAR John Smith		24b. REGISTRAR'S SIGNATURE John Smith		

BURZAU V. A.

PERGEIYED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #9-Film G227-4/10/58-mb

03201

3218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i>	b. COUNTY <i>Cecil</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>	c. LENGTH OF STAY IN lb <i>life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>	d. STREET ADDRESS <i>x</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Eliza</i>	First <i>Eliza</i>	Middle <i></i>	Last <i>WILSON</i>	4. DATE OF DEATH <i>March 29 1958</i>	Month <i>March</i>	Day <i>29</i>	Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10 1879</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>our Home</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>William Harris</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Arnetta Brown 616 Grubbs Place Cecilton</i>	Address <i>Arnetta Brown 616 Grubbs Place Cecilton</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> DUE TO (c) <i>Cerebral Atherosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>			
21. I certify that I attended the deceased from <i>Jan 4, 1958</i> , to <i>Mar 29, 1958</i> , that I last saw the deceased alive on <i>Mar 29, 1958</i> , and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Wallace Oberhain</i>	PHYSICIAN'S NAME (Type) <i>Wallace Oberhain</i>	ADDRESS <i>M.D.</i>	ADDRESS (Street, city or town, state) <i>Cecilton, md</i>	DATE SIGNED <i>1 Apr 58</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/2/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cecilton Cemetery</i>	22d. LOCATION (City, town, or county) <i>Cecilton</i>	(State) <i>md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Waller Wellington</i>	ADDRESS <i>Wellspring Md.</i>	24a. REC'D BY REGISTRAR DATE <i>APR 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>West Smith</i>					

BUREAU V. S.

APR 7 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03202

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 10 yrs 7 mos 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. VITAL RECORDS 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 5111 Sunset Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Milton (NMI) WINNER		First Milton	Middle (NMI)	Last WINNER	4. DATE OF DEATH March 29,	Month March	Day 29,	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-23-14	9. AGE (in years last birthday) 44	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Winner				14. MOTHER'S MAIDEN NAME Fannie Mazer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Not ascertainable Hospital Records, VAH, Perry Point, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO 4/20.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 3-30-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt Carmel		22d. LOCATION (City, town, or county) Baltimore			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc 2100 Eastern Avenue		ADDRESS 2100 Eastern Avenue		24a. REC'D BY REGISTRAR DATE 3-30-58		24b. REGISTRAR'S SIGNATURE Av. Lewis			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURLAU V. E.

APR 2 1963

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